

***U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
89th Meeting of the CSAT National Advisory Council (NAC)***

August 29, 2023

Open Session Minutes

***5600 Fishers Lane Rockville
MD 20857***

Certified 11/27/2023
Yngvild K. Olsen, M.D., M.P.H
CSAT Center Director CSAT NAC Chair

OPEN SESSION MINUTES

Call Meeting to Order

The 89th CSAT National Advisory Council (NAC) meeting commenced at 9:00 a.m. EDT on August 29, 2023, and the CSAT NAC Designated Federal Officer (DFO) officially called the meeting to order. Her first order of business was to conduct a roll call of council members to ascertain the presence of a quorum, which was successfully established. The DFO proceeded with essential housekeeping and protocol announcements to ensure the efficient and orderly conduct of the meeting. Three council members were physically present, and six participated virtually through Zoom. Subsequently, the DFO introduced Dr. Yngvild K. Olsen, Director of CSAT, and Chair of the NAC, who presided over the meeting.

Welcome, Opening Remarks

Dr. Olsen began by extending her gratitude to all council members for their participation and expressing her appreciation to Dr. Dianne Clark, who joined virtually despite the impending Hurricane Idalia in Florida. She acknowledged the somber context of recent shootings in Jacksonville, Florida, and at the University of North Carolina. Knowing that many shootings are racially motivated, Dr. Olsen mentioned a presentation that afternoon by Twyla Adams, CSAT's senior advisor on equity, focusing on the issues of stigma, discrimination, and racial inequities associated with substance use disorder (SUD).

Dr. Olsen welcomed the five new members of the NAC. She emphasized the importance of their varied backgrounds, perspectives, expertise, and insights in addressing the complex challenges of SUD treatment, and ultimately improving lives and communities.

Dr. Olsen proceeded to outline the day's agenda, which would begin with self-introductions by each member, an overview of CSAT, and updates on the work of CSAT's various divisions and branches. Subsequently, there would be an opportunity for discussion and questions before the lunch break.

After lunch, Dr. Miriam Delphin-Rittmon, Assistant Secretary for Mental Health and Substance Use, and the Administrator of SAMHSA, would provide an overview of SAMHSA, followed by guest speaker presentations from Twyla Adams and Christine Rodriguez. Ms. Rodriguez, from AIDS United, would delve into SAMHSA's Harm Reduction Framework. The afternoon would also feature additional opportunities for council discussion and questions. To conclude the meeting, Dr. Olsen would summarize the day's accomplishments and formally adjourn. She reminded members about the Joint NAC meeting scheduled for the following day, Wednesday, August 30. This meeting facilitates interactions between CSAT NAC members and their counterparts from other center NACs, enabling the exchange of valuable information on topics of mutual interest to SAMHSA and the behavioral health field. Additionally, she alerted

the group to the SAMHSA NAC meeting on Thursday, August 31, which is open to the public, including CSAT NAC members, and allows broader engagement and collaboration.

Member Introductions and Updates

Each council member introduced themselves in alphabetical order, and described their backgrounds. The members who attended the meeting in person were Dr. Wesley Geminn, Dr. Jorge Petit, and Dr. Kenneth Stoller. All other members participated virtually.

Dr. Dianne L. Clarke is the CEO of Operation PAR—an extensive SUD treatment program that provides medications for addiction treatment and other services and operates in eight Florida counties, all of which were under flood and hurricane warnings and preparing to shut down. The organization serves over 4,500 people across these settings every day. Given the weather warnings, they have been busy arranging take-home dosing and preparing to be without power.

Dr. Wesley Geminn is the Chief Pharmacy Officer for the Tennessee Department of Mental Health and Substance Abuse Services, where he also serves as the Tennessee State Opioid Treatment Authority (SOTA). His professional interests include addressing access to quality care in the realm of SUDs, and he engages in outreach and education efforts targeting community pharmacies, pharmacy leaders, and pharmacy schools. He strives to raise awareness about SUDs and underscore how pharmacists can be pivotal in supporting individuals facing SUD challenges. Tennessee has established comprehensive statewide buprenorphine treatment guidelines for nonresidential settings. Dr. Geminn is at the forefront of efforts to ensure that these guidelines are officially adopted as policy by licensure boards. He also seeks to create a more compassionate and informed approach to SUD within the pharmacy community.

Dr. Ruchi M. Fitzgerald is a family physician and an addiction medicine specialist in Chicago, Illinois. She has a faculty appointment at Rush University in the Departments of Family and Preventive Medicine and Psychiatry and Behavioral Health Sciences. She is also the Associate Program Director of the Rush University Addiction Medicine Fellowship. She provides clinical services at the PCC Community Wellness, a Federally Qualified Health Center (FQHC) that cares for medically underserved populations on Chicago's West Side. Additionally, Dr. Fitzgerald is the Chief of an addiction medicine consultation service at a safety-net hospital in Chicago that serves patients at high risk of medical complications, overdose, and death from SUDs. SUD and other social determinants of health disproportionately impact these patients. Her interests within addiction medicine center on older adults, pregnant and parenting persons, and other special populations.

Dr. Lois M. Jircitano is a retired professor with expertise in educational leadership and law. Dr. Jircitano has both a Doctorate in Law and Jurisprudence and Doctor of Philosophy in Educational Administration, Leadership and Policy awarded from the State University of New York at Buffalo. She has taught at the doctoral level at Western Kentucky University and D'Youville University, Departments of Educational Leadership.

Ms. Tara Moseley Hyde holds the CEO position at People Advocating Recovery, an organization in Louisville, Kentucky, which serves 120 counties across the state to provide Narcan and harm reduction support. She also serves as a policy strategist, collaborating with recovery support and

treatment organizations statewide. She seeks to enhance their capacity to offer the full continuum of care, encompassing harm reduction, treatment, and recovery to support individuals in need. She served as Vice President of Programs for Young People in Recovery in Louisville. It was the twelfth chapter in the country, which has since expanded to 12 chapters throughout Kentucky and 80 chapters nationwide. As a person in long-term recovery, Ms. Hyde draws upon her own lived experiences, which include periods of homelessness and financial hardship, to help address the challenges and barriers individuals face when seeking treatment and recovery. Her efforts also focus on creating pathways to upward mobility and success in life for those in recovery.

Dr. Charisse Evonne Peoples serves as the Staff Psychologist at the Reentry and Sanctions Center—an intervention program under the auspices of the Court Services and Offender Supervision Agency in the Washington, DC area. She has been with the program for 14 years. This agency engages in law enforcement activities aimed at supervising individuals placed on probation, parole, and supervised release. They maintain partnerships with the U.S. Bureau of Prisons, the U.S. Parole Commission, psychiatric hospitals, community mental health centers, and various community agencies. They have a sister agency, the Pretrial Services Agency, in Washington, DC. Dr. Peoples provides a range of psychological services at the 102-bed facility, including psychological evaluations, psychosocial assessments, and psychiatric services. The client population primarily comprises adult African Americans with substance use issues and co-occurring mental health and developmental challenges who are under supervision. The program's overarching goal is to develop and integrate a case plan that enables probation officers to work with supervisees effectively and to facilitate the successful completion of supervision while minimizing the risk of recidivism.

Dr. Jorge R. Petit has served as a public sector psychiatrist in New York, New York, for nearly three decades. Most recently, he was CEO of one of the largest New York State Health and Human Services agencies. The organization was at the forefront of providing a continuum of holistic services for individuals with developmental disabilities, mental health concerns, and SUDs. The agency operated shelters, offered supportive housing solutions, and delivered comprehensive wraparound services. These services ranged from medical and dental care to pharmacy services, mental health support, substance use treatment, and even urban farming initiatives to address food insecurity issues. A notable achievement was the launch of the first public health vending machine in New York City, strategically placed in an area with high rates of SUDs. Dr. Petit is a strong proponent of harm reduction principles.

Dr. Kenneth Stoller is an Addiction Psychiatrist at Johns Hopkins in Baltimore, Maryland, who has filled various roles in the field of addiction medicine. This includes serving as the Medical Director of Outpatient Addiction Treatment Programs at Johns Hopkins Hospital. In addition to his outpatient work, he plays a role in the hospital's dual diagnosis units, where they provide specialized care for patients living with both addiction and mental health challenges. He also serves as the Behavioral Health Medical Director for Johns Hopkins Health Plans, overseeing a range of healthcare programs, including a Medicaid Managed Care Organization, an employer's health plan, a military health plan, and a Medicare Advantage plan. Many of the patients within these plans face significant social determinants of health, such as homelessness or unstable housing situations, that hinder their recovery. He is involved in initiatives that provide

temporary housing solutions to facilitate transitions for these patients. Dr. Stoller is also a member of a group at the National Academies of Medicine that focuses on equity issues in healthcare. This includes identifying and addressing barriers to seeking and accessing treatment and medications for opioid use disorder (MOUD).

Dr. Emily Tanner-Smith is a Counseling Psychology and Human Services Professor at the University of Oregon. With training as a sociologist and statistician, her primary area of expertise is utilizing evidence-synthesis methods to assess and summarize research related to the efficacy of substance use prevention and treatment efforts. Recently, she has directed her focus towards school-based recovery support for young people grappling with substance use issues. Much of her work has involved studying the effectiveness of recovery high schools and collegiate recovery programs in supporting students who are transitioning out of treatment and reintegrating into academic environments while sustaining their recovery. She played a role in collaborative efforts with the Oregon Recovery High School Initiative, which resulted in state funding to establish multiple recovery high schools in Oregon. In addition, Dr. Tanner-Smith directs the HEDCO Institute for Evidence-Based Practice at the University, which is a hub for consolidating and disseminating evidence on the effectiveness of various school-based activities in supporting students' mental and behavioral well-being.

Upon completing the self-introductions, Dr. Olsen acknowledged the rich diversity among the NAC members. She highlighted the wide-ranging backgrounds, experiences, areas of focus, and age groups served. She recognized the group's dedication and commitment to individuals grappling with SUDs and the desire to effect meaningful change in their lives. She underscored the importance of their role as Council members in ensuring that CSAT's activities remain grounded in evidence-based practices and continue to push the field's boundaries for the betterment of people affected by SUDs. She concluded by inviting questions, though there were none.

Consideration of the April 25, 2023, Minutes

The DFO entertained a motion to adopt the minutes of the April 25, 2023, meeting, which the DFO electronically forwarded to all members for review and comment. They have been certified in accordance with the Federal Advisory Committee Act regulations and include all submitted edits. Dr. Stoller moved to adopt the minutes. The DFO invited any discussion, but there was none. Dr. Geminn moved to accept the minutes, and the minutes were adopted by unanimous vote.

CSAT Division/Office Director's Update

Dr. Olsen commenced the next segment of the agenda, during which the CSAT Division Directors and Branch Chiefs delivered updates. Recognizing that the presentation by the Office of Performance Analysis and Management (OPAM) on CSAT's data management would likely be lengthier than the others, it was the initial presentation. She assured attendees that time would be allocated for discussion and questions after each presentation.

Topic: Office of Performance Analysis and Management (OPAM)

Talisha Searcy, MPA, MA, Director, OPAM, presentation focused on the Substance Use, Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG), which was formerly the Substance Abuse Prevention and Treatment Block Grant program. The presentation had three goals: to provide an overview of the SUPTRS BG data reporting requirements, to highlight key takeaways from the SUPTRS BG data quality activities, and to discuss the next steps. Office accomplishments to date include conducting a data quality assessment and data learning collaboratives with some states to improve understanding of the challenges they are experiencing.

SAMHSA's Strategic Plan highlights the agency's commitment to using data and evidence to guide priority areas and ensure that programs achieve intended goals. This includes improving data methodologies the SUPTRS BG program employs to collect, share, and use SUPTRS BG data to improve the program. In FY23, SAMHSA was appropriated \$2 billion in SUPTRS BG funds. In the 2023 Consolidated Appropriations Act, Congress required modifications to the SUPTRS BG, which included new requirements that reporting on recovery support services be added to the FY24-25 application and that data from the SUPTRS BG be made more available to users. The priority services are those for primary prevention, tuberculosis, early intervention for HIV/AIDS in designated states, substance-using pregnant women and women with dependent children, and persons who inject drugs. The SUPTRS BG prevention funds also support the implementation of Synar. Grantees cannot exceed 5 percent of grant funds for expenditures related to grant administration.

Two main systems capture SUPTRS BG data related to substance use treatment. The Web Block Grant Application System (WebBGAS) is an administrative, electronic application and data platform through which grantees can apply for SUPTRS BG funds and submit required reports. The Treatment Episode Data Set (TEDS) is a separate dataset in which state facilities that receive public funding can submit client-level episodic data on SUD treatment related to admissions and discharges. Most states and territories use the system to report data to SAMHSA.

. In 2020, a Government Accounting Office (GAO) report highlighted issues with data reliability on the number of individuals served using SUPTRS BG funds. This followed a 2009 evaluation of the quality of SUPTRS BG data that had highlighted data issues for reporting on individual and system level outcomes and unmet technical assistance and training needs.

While SAMHSA had responded to the 2009 report with increased TA and training, the GAO report findings challenged SAMHSA's ability to determine the extent to which the SUPTRS BG is achieving the agency's goal of improving access to SUD treatment and recovery. In 2022, OPAM addressed SUBG program integrity issues and challenges in collecting and leveraging those data through a program data quality assessment. This included a survey and focus groups of states (SUPTRS BG grantees) grantees to explore how data is captured and used and the nature of barriers and challenges encountered. Findings from the data quality assessment included: 1) grantees mostly collect data through a Web-based data collection and monitoring system with external vendors often collecting client-level administrative and claims data in systems that either interface or upload information from subrecipient (provider) electronic health records (EHRs); 2) most grantees store data on their premises, and others store it in the cloud; 3)

grantees overwhelmingly use computer-based data collection and monitoring to capture data on expenditure and fund allocations. However, one-fourth of grantee subrecipients still use paper-based forms in general and stored their SUPTRS BG data in paper-based filing systems.

Other findings from the quality assessment project round out the final report. Barriers and challenges that exist with SUPTRS BG data collection include a lack of health IT infrastructure to support data collection and monitoring systems, insufficient data collection capacity at the service provider and/or subgrantee level, and difficulty getting service providers/sub-grantees to collect the data. Grantees found that most funding allocation data could be reported without difficulty except for Medicaid funds and maintenance of effort (MOE) expenditures. It was relatively easy to report on the number of people served, but unduplicated counts by demographic group and services rendered took time. Most grantees were able to report data on funded services related to SUD but wanted to begin collecting more data on physical health (e.g., client COVID screening status and comorbidities).

OPAM conducted a webinar for states on lessons learned from this project and have since hosted learning collaboratives to improve data reporting. These data quality learning collaboratives were held from March through August this year and focused mainly on best practices in data quality frameworks and measures. They also included discussion of strategies for creating targeted communications and contracts with substance use treatment providers to ensure timely and accurate reporting and for working effectively with data partners. Other topics covered included strategies for enhancing data quality from the grassroots level by incentivizing service providers to generate the necessary data and ensuring they acquire data directly from clients. Additionally, the collaborative explored methods to differentiate and record data related to the provision of recovery support compared to the data associated with direct clinical treatment. The state showcase was a notable aspect of the learning collaboratives, during which grantees shared their experiences utilizing the collected data.

The next steps for OPAM include revising future reporting requirements and monitoring to include data on recovery support services, and harm reduction; modifying compliance review data criteria; identifying ways to improve the WebBGAS system to increase the transparency of SUPTRS BG data; and utilizing their interagency agreement with the Office of the National Coordinator for Health IT (ONC) on data standards and technology solutions for grantees.

Council Discussion/Questions

Dr. Petit commented that what is missing is real-time, actionable, meaningful data that service providers can use to help their clients. In New York where he worked, in addition to the SUPTRS BG requirements, they input data into a city database but do not get access to it. He asked if a more centralized approach or platform exists to integrate these disparate data streams. Due to burdensome provider data reporting requirements, they have turned down many federal grant funding opportunities. Also, there is a client-consent burden because, in New York, clients must sign numerous consent forms to enable the staff to view their data. He asked if data requirements could be approached more holistically.

Ms. Searcy acknowledged the validity of Dr. Petit's comments as various states have expressed similar concerns. The OPAM is trying to identify ways that technology can be used to collect core data elements that are germane across the board. She has held conversations with the ONC on this topic. Regarding the client-consent burden, the OPAM is open to receiving additional insights on this piece, which is challenging. Adding to the problem, more states allow children to consent to services themselves. Ideas such as a patient consent portal that would have a trickle-down effect have been discussed, although, with grants, it becomes more complex.

Dr. Olsen explained that a challenge is the need for interoperable EHRs since about 25 percent of SUPTRS BG sub-recipients still use paper-and-pencil methods.

Dr. Stoller asked if SAMHSA could develop a systematic categorization and description system for grants and their associated data. This system would enhance accessibility and usability for a wide range of stakeholders, including providers, policymakers, health plans, hospitals, and oversight bodies. It could prevent unnecessary duplication of efforts as the professional field expands. Furthermore, it has the potential to streamline data analysis and enable academics and other interested parties to publish findings derived from the data. This initiative also dispels the perception that data collection primarily serves administrative auditing purposes and demonstrates its value in assisting grant recipients in supporting clients and improving services.

Dr. Fitzgerald agreed with Dr. Stoller's idea. She noted the special reporting burden placed upon SUPTRS BG sub-recipients in understaffed and smaller community organizations. The Single State Agency (SSA) tells them to submit the SUPTRS BG data to SAMHSA, but the data collected is not shared with them. Also, given that the funding cycle is for only one year—and not knowing if the grant will be renewed—the reporting burden seems immense. But they do it to receive funding. Adding to the frustration, no evaluation has taken place that could help address some of these issues.

Dr. Robert Baillieu stated that SAMHSA is creating a data strategy based on 23 listening sessions with over 100 stakeholders that address many of the concerns expressed today (e.g., return data to grantees, make data actionable, create dashboards, allow funds for data analysis at the grantee level for quality improvement; address data collection burden).

Ms. Searcy added that SAMHSA has several additional contracts underway that will provide TA to grantees on data-related matters and expressed that it doesn't make sense to collect data that is not being used.

Dr. Olsen commented that the SAMHSA grantees are states and that as grantees of the state, community-based organizations would be considered "sub-recipients." So, how would sub-recipients receive up-to-date information on what SAMHSA does with that data? It signifies that we must consider how SAMHSA can work with states and subrecipients to convey how the data is used.

Dr. Geminn stated that we need to work smarter together to ensure that providers on the ground are delivering care to patients and not just entering data that goes into a hole. He said the data collected must be actionable and useful. His organization uses a methadone central registry that

gives timely access to their data and provides updates on its use, which helps drive decision-making and policy. He asked if SAMHSA has explored why certain programs still collect paper-based data.

Ms. Searcy responded that there are costs associated with acquiring EHR technologies, which some providers, such as smaller practices, find too costly to adopt, especially if they do not see any real benefit. The OPAM is working with SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) and the ONC to add a health IT supplement to the National Substance Use and Mental Health Services Survey (N-SUMHSS), which is a survey of behavioral health facilities through which SAMHSA can ask providers if they have an EHR and get a better handle on their technological capabilities.

Dr. Geminn added that although expensive, most EHRs have some application programming interface (API) functionality. He is the business sponsor of his state's EHR for psychiatric hospitals, and they find this tool to be amazing but highly costly at \$90,000. He suggested that a subsidized approach for increasing accessibility to EHR technology should be considered.

Ms. Searcy indicated that the pilot project would explore resources to help providers with EHR costs and implementation strategies. It is a threefold project that involves understanding what people have, identifying gaps in data standardization and what could be ultimately incorporated into the U.S. Core Data for Interoperability (USCDI), and piloting a system.

Topic: Office of Program Analysis and Coordination (OPAC)

Chau Pham, Director, OPAC, provided an overview of the OPAC. The office supports CSAT in implementing programs and policies by guiding the administration, analysis, planning, and coordination of CSAT programs consistent with SAMHSA's priorities. They work with the Office of the Director (OD) to provide direction and oversight of CSAT's participation in SAMHSA policies, planning, and budget formulation and execution. OPAC also provides coordination, advice, and guidance to all programs in contract planning and development activities. Also, they disseminate clear and accurate information about policies and procedures, laws, regulations, and other factors related to grants and contract management. Furthermore, they coordinate with all GAO and Office of the Inspector General (OIG) engagements and inquiries, reports to Congress, and provide administrative coordination.

In FY19, the budget total for CSAT was \$3.8 billion, which increased to \$4.2 billion in FY23. This is an increase of \$338 million, or 9 percent, from FY19. These funds are used for the Programs of Regional and National Significance (PRNS), the State Opioid Response (SOR), and Substance Use Block grants. OPAC's priority is to ensure the accurate obligation of funds toward the year-end process. They continue to provide program and policy support to ensure full utilization of FY23 funds without lapses. They also provide forecasts for new grants, awards, and contracts in FY24 and prepare for the FY25 budget proposal.

OPAC accomplishments in FY23 include approval and execution of funds for the 844 continuation grants and coordination with divisions and offices on the budget formulation for FY 25; collaboration with program offices to complete 22 Notice of Funding Opportunity (NOFOs);

and receipt of over 1,100 applications with 363 awards (32 percent) to grantees. They completed 19 funding plans and scheduled lesson-learned sessions related to funding plans and NOFOs. They also managed 17 active GAO and OIG engagements.

Dr. Olsen explained that when active OIG and GAO engagements are underway, it signifies a heightened level of interest in and scrutiny of CSAT's activities. She emphasized that the SOR and SUBG account for the largest portion of CSAT's budget, but with recent expansion of PRNS and some smaller discretionary grant programs. She pointed out that CSAT has been able to fund only about one-third of the grant applications it receives, underscoring the significant need in the field for resources. Dr. Olsen also expressed the intention to explore avenues for growth as they work on developing the FY25 budget within the upcoming Federal Government budget cycle. This cycle involves managing three budgets concurrently, spanning three different fiscal years.

There were no further discussions or questions.

Topic: Division of Pharmacologic Therapies (DPT)

Patti Juliana, Ph.D., Director, DPT, gave an overview of the DPT's function, structure, and activities. The Division promotes and supports medication-related activities and treatment services and assures adherence to Part 8 through the Opioid Treatment Programs (OTPs), the Controlled Substances Act, and more recently, the Medication Access and Training Expansion (MATE) Act. The DPT operates within three distinct domains: the Regulatory Branch, responsible for overseeing OTPs (Opioid Treatment Programs); Accreditation Oversight; and the latest addition, the Provider Support Branch. Within the Regulatory Branch, the governing authority derives from the 42 CFR and the Controlled Substances Act. The budget allocation supports staffing needs and the Buprenorphine Waiver Notification System (BWNS). Notably, the BWNS continues to house a substantial number of records sought by individuals as evidence of their completion of the training mandated by the MATE Act.

In the next year, the DPT will add 22 new universities to the Provider Clinical Support Systems Universities grant program. . They also are proposing an OTP technical assistance contract to help implement the revisions to Part 8. There are 15 new grantees with the Emergency Department Alternatives to Opioids, issued out of the Substance Use-Disorder Prevention and Treatment for Patients and Communities (SUPPORT) Act and continued in the Consolidated Appropriations Act. The Comprehensive Opioid Recovery Centers were also established through the SUPPORT Act to ensure that individuals in recovery centers had access to methadone and other medications for opioid use disorder.

The DPT actively pursues four key priorities of SAMHSA: preventing overdose, integrating behavioral and physical healthcare, promoting resilience, and strengthening the behavioral health workforce. Over the past year, DPT's initiatives included revising 42 CFR Part 8 and collaborating with expert panels and numerous universities to incorporate substance use education into healthcare and allied professions curricula.

Additionally, the DPT focused on integrating MOUD into criminal justice settings and drafted guidelines for states to facilitate the implementation and integration of MOUD. They also engaged with SOTAs, organized a Policy Academy in the summer (with another planned for FY24), and partnered with the Division of Services Improvement (DSI) to host a Youth Summit, emphasizing MOUD for adolescents and young adults. They also developed NOFOs.

Looking ahead, the DPT plans to provide training and technical support to states and OTPs. They will collaborate with accreditation bodies to update any necessary standards based on a final Part 8 rule, continue efforts to expand access to MOUD within criminal justice systems and behavioral health centers, and establish partnerships with FQHCs. Their overarching goal remains to enhance the capacity of mainstream healthcare and behavioral healthcare providers to address SUDs and related medical and mental health issues effectively.

Topic: Regulatory Programs Branch, DPT

Nichole Smith, Branch Chief, familiarized the council with the functions and activities of the Regulatory Branch within the DPT. The Branch is responsible for the day-to-day oversight of SAMHSA's OTP regulations codified in the 42 CFR Part 8. Core tasks of the Branch include certification and accreditation; encouraging the expansion of access to MOUD by supporting prisons that want to provide methadone by becoming an OTP; encouraging the implementation of mobile units; and encouraging collaborations between OTPs, FQHCs, Certified Community Behavioral Health Clinics (CCBHCs) and prisons to foster integration of behavioral health and primary care. They also devoted significant time to revising 42 CFR Part 8. These efforts were focused on updating elements identified in the literature and from feedback as being essential to promoting effective treatment and practice in OTPs and reflecting the current OTP accreditation and treatment environment. Also, the proposed rule is consistent with the HHS Overdose Prevention Strategy and the Office of National Drug Control Policy's 2022 National Drug Control Strategy, both of which call for increasing access to evidence-based treatments for SUDs.

Ms. Smith stated that the Branch has 73 new OTPs since January 2023, for a total of 2,026 certified programs as of August 2023. There are 26 new active brick-and-mortar medication units since January 2023 and 32 total mobile medication units, which is an increase of 18 new mobile units since the DEA's updated guidance in 2021. They continue to provide technical support to the Bureau of Prisons as they have seven primary OTPs and 89 brick-and-mortar medication units and offer telehealth flexibilities. This year, the Regulatory Branch provided two webinars on mobile units with the American Association for the Treatment of Opioid Dependence (AATOD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD), as well as in-person training to DEA field agents in Florida on the provisional application process.

In terms of accreditation, Ms. Smith indicated that the Branch renewed agreements with all accreditation bodies (ABs) and has experienced improved collaborative relationships with ABs through monthly meetings and engagement in efforts such as the MOUD and State Prison Policy Academy, work with the Bureau of Justice, and revision of standards of 42 CFR Part 8. The standards outline the role of the ABs and SAMHSA's expectations of their performance.

Future plans include establishing a new OTP technical assistance program, assisting with evaluating the results of OTP accreditation surveys, assisting OTPs in adapting to the revisions in Part 8, and providing direct assistance requested by the OTPs. The Branch also plans to finalize the proposed revisions in Part 8 and revise the federal OTP guidelines, to provide webinars to SOTAs and OTPs to encourage OTP collaboration with other services, and to enhance DPT's oversight of all ABs through monitoring and evaluation.

Topic: Provider Support Branch, DPT

Michele Monroe, Branch Chief, acquainted the NAC members with DPT's newest unit—the Provider Support Branch—established this year and that included the Drug Addiction Treatment Act (DATA) Waiver Program before its elimination. They continue to provide training and support to practitioners and organizations with questions through a call line and website content. With the waiver elimination, potentially 1.9 million healthcare providers may be eligible to prescribe buprenorphine for the treatment of opioid use disorder. The Provider Support Branch is working to increase providers' ability to treat SUDs through education with the Providers Clinical Support System (PCSS)-Universities and Office of the National Drug Control Policy (ONDCP) initiatives to integrate SUD curriculum into healthcare education. There are also PCSS cooperative agreements for MOUD and MAUD and Emergency Department Alternatives to Opioids Program (ED-Alt) grants.

Ms. Monroe reviewed Branch accomplishments, which include establishing the Branch and the Branch Chief position; facilitating the implementation of the MAT and MATE Act provisions of the Consolidated Appropriations Act ; collaborating with the DEA on matters related to the waiver elimination and provision of educational materials, webinars, and similar resources; and retraining and retooling of Branch staff previously assigned to the DATA waiver program. They also assisted providers, patients, and pharmacies in understanding and navigating the waiver elimination so that the change did not harm patients; reviewed State laws that had waiver requirements with SOTAs and worked with 29 states; developed recommendations and identified resources for the MATE curriculum requirements; drafted guidelines for states on integration of MOUD in criminal justice settings; and supported the first cohort of five states through the Policy Academy.

Council Discussion/Questions

Dr. Geminn indicated that at the state level in Tennessee, he published public guidance due to the receipt of many inquiries from lawmakers and providers about waiver elimination. Tennessee is a MAT-resistant State, so laws and rules that further restrict the use of buprenorphine had to be clarified. Last month, he held a listening session with providers and lobbyists who indicated, surprisingly, they were in support of having a state-level DATA waiver equivalent in terms of the training it affords. They were concerned that there would be new prescribers of buprenorphine that did not have proper training. However, removing the DATA waiver has mostly resulted in the same prescriber levels in Tennessee. He will continue to promote training.

Dr. Olsen commented that the April 2021 buprenorphine guideline issued by HHS included removal of the training requirement and resulted in a significant increase in the number of prescribers (i.e., mostly emergency department physicians) but not a large increase in the number of patients.

Dr. Clarke remarked that she attended the webinar on mobile units, which she found informative and made a big difference in Florida. One approach they are taking in Florida is leveraging the CCBHC model and using opioid settlement money to direct that integration. They are applying for much of the local settlement money to be directed towards mobile units. However, there appears to be confusion between DEA licensing of mobile units and how that is done in light of other local licensing issues. She further remarked that given 96 new OTPs since January 2023, stigma and discrimination are still associated with any SUD, not only OTPs.

Dr. Olsen concurred that stigma still abounds and keeps individuals from accessing and remaining in treatment and potential providers from offering it.

Dr. Stoller commented that stigma related to HIV began to decrease when quality treatments emerged. He stated that the Provider Support Branch is especially important now that there are potentially more providers, and there is no guarantee of 8 hours of pertinent training on best practices related explicitly to buprenorphine. The key is to support improved quality and avoid having states and counties compelled to implement more barriers in response to poor quality healthcare. He commended SAMHSA for its partnership with the DEA in various areas. He expressed hope for similar collaboration with the Centers for Medicare and Medicaid Services (CMS) on reimbursement structures for OTP services and peer services, realistic requests by CMS auditors, and others.

Topic: Division of State and Community Systems (DSCS)

In the absence of the Division Director, C. Danielle Johnson Byrd, Spencer Clark presented the update on the DSCS. The Division is comprised of two Branches—one is responsible for the block grant, with a budget of slightly over \$2 billion, and the other for the SOR grant, with a budget of \$1.5 billion. He listed the priorities of the Division, which are the SOR Report to Congress in 2023, the SOR NOFO for 2024, the development of recovery supports guidance for the block grant, additions and changes to the block grant website, and hiring staff for both branches. Authorities under which the DSCS acts are the Consolidated Appropriations Act and the SUPTRS BG through Part B, Subparts II and III of the Public Health Service Act and regulations. In the past year, CSAT has focused heavily on a top priority for SAMHSA, overdose prevention. Both branches have participated in the Naloxone Saturation Policy Academy.

This year's major push for the SUPTRS BG has been a rewrite of the application and reporting components in coordination with the Center for Mental Health Services (CMHS). They have a combined application currently in use by applicants for 2024. Upcoming plans include proposed revisions to the SOR formula, the SOR Naloxone Saturation Policy Academy, the Report to

Congress on contingency management, and continued technical assistance to the states on the new SUPTRS BG requirements.

Topic: State Opioid Response Branch, DSCS

Jenifer Rutter Gianello, M.Ed., LPC, Branch Chief, shared the accomplishments of the State Opioid Response Branch. The SOR is a \$1.5 billion program that began in 2018. It is a 2-year grant program, and since the Branch's inception, over 1.2 million individuals have received treatment for opioid use disorder through SOR funds. Over 1.1 million individuals have received recovery support services in the same period. The most common treatment received is buprenorphine. SOR recipients have distributed over 8.1 million Naloxone kits with over 500,000 overdose reversals through grant funds. The SOR grant recipients distributed over 2.6 million fentanyl test strips through SOR funds. The SOR/TOR technical assistance grant that was awarded to the American Academy of Addiction Psychiatry (AAAP) in FY22 served over 16,000 individuals from October through June of this year with training, TA, and education, and they have delivered over 6,000 different activities through their large network of providers and consultants across the country. The major priority for the SOR branch is to provide ongoing education and TA to the grantees to assist with grant implementation (e.g., data collection, reporting, goals, and objectives). They are working on the FY23 SOR Report to Congress and will continue working with SOR grantees to develop and refine their Naloxone saturation and distribution plans. Since the last NAC meeting, they conducted an in-person Naloxone Saturation Policy Academy with ten states and a virtual follow-up meeting.

Topic: State Systems Partnership Branch, DSCS

Mr. Clark, MSW, LMSW, ACSW, Branch Chief, SSPB, stated that the greatest task this year of the Branch has been implementing the OMB-approved application and plan. The WebBGAS system, referred to earlier by Ms. Searcy, is the automated system SUBG grantees use to provide a substantial plan each September/October and an annual report in December. The Branch conducted several presentations and webinars on the new application and WebBGAS. They also provided TA, held two highly successful learning collaboratives, and participated in the Naloxone Saturation Policy Academy. A recent funding supplement of \$15.4 million will go to states for training and TA on evidence-based practices, emphasizing Naloxone saturation planning and overdose planning.

He told the group that Branch priorities include continuing implementation of the Consolidated Appropriations Act (noting the removal of the word *abuse* from the Act and replacement with the word *use*), reporting of data on recovery support services and expenditures by type, and consideration of a recovery set-aside in the President's Budget as informed by data on recovery support services already provided through the block grant. A robust new catalog of recovery support services states offer can be found on the SAMHSA website.

Currently, the Branch is focused on preparing the plans and reports for the coming year. Since 2021, their funding has increased substantially through three appropriations extending through either FY24 or FY25. These monies are in addition to their standard funding and supplement

funding. Some states have experienced challenges in using these increased funds productively and efficiently, and the Branch stands ready to assist wherever needed.

Council Discussion/Questions

Dr. Stoller posed two questions. The first one concerns how the Report to Congress on contingency management relates to SAMHSA's ongoing work to revise laws or regulations to give providers the ability to provide more meaningful contingency management/ The second one is whether Nalmefene is part of the future plan in addition to Naloxone.

Dr. Olsen explained that in the Consolidated Appropriates Act, there is a requirement for HHS to develop a Report to Congress on contingency management. SAMHSA has been looking at thresholds and evidence related to contingency management. She also explained that SAMHSA has received requests from a few states asking if their SOR funds can be used to support Nalmefene, and these requests have been honored. She noted that the language in upcoming NOFOs must change based on new options and other policy changes.

Topic: Division of Services Improvement (DSI)

Darrick Cunningham, LCSW, BCD, Director, DSI, reported that the DSI is a large division with three branches and diverse programs. The Division's priorities align with SAMHSA's and encompass promoting resilience and emotional health for children, youth, and families; enhancing access to suicide prevention and crisis care; integrating behavioral and physical healthcare; strengthening the behavioral health workforce; and preventing overdose. Key accomplishments of the Division include Grantee/GPO partnerships, collaboration, and interactions to enhance performance; offset of \$16.5 million for FY23; funding of 30 additional grant awards; and management of Congressionally directed spending (CDS) projects or earmarks. Future plans and activities include DSI's ongoing emphasis on customer service, standardization of processes, management of over 1,200 grants, Government Performance and Results Act (GPRA) modernization, and development of the contract officer representative (COR) workforce.

Topic: Special Populations Branch, DSI

Andrea M. Harris, M.S., Branch Chief, reported that the Special Populations Branch houses CSAT's Pregnant and Postpartum Women programs; the adolescent and young adult treatment programs; the criminal justice programs; and the Screening, Brief Intervention, and Referral to Treatment (SBIRT) program. Branch priorities include developing an expert panel on trauma-informed treatment courts; orienting approximately 200 new grantees; educating and training healthcare providers, family, and school personnel on MOUD for youth; managing a new program—the Prevention, Youth Overdose Treatment, Recovery, Education, Awareness, and Training (PYO) treatment grant; reducing risk for mothers and their infants through funding new grants in the Pregnant and Postpartum Women program; and continuing collaborative learning and information sharing with grantees via learning communities.

Key accomplishments include the first-ever CSAT Youth SUD Summit with a follow-up planned for next year, the annual SBIRT Grantee Summit, 192 new grants across all Branch portfolios, and the new NOFO for the PYO. The Branch also revised a suite of resources for professionals, people with lived experience, and providers who work with pregnant individuals with SUD, which is available in the SAMHSA Store.

Future work includes planning the follow-up event for the Youth Summit, award of the state pilot for Pregnant and Postpartum Women programs, and integrating MOUD into their youth programs, especially the PYO treatment program. Additionally, the Branch will expand adolescent programming to include residential treatment; develop a work plan for the Gather, Assess, Integrate, Network, Stimulate (GAINS) Center contract, which supports their criminal justice programs nationwide; and facilitate orientation webinars for new grantees in the adult treatment drug courts, the Offender Reentry Programs, and the PPW pilot, residential, and youth and family tree programs. They will continue supporting the reporting needs and disseminating information from the HHS Maternal Health Task Force.

Comment/Discussion

Dr. Jircitano asked if Branch funding would extend to school districts through a state agency or a direct federal grant. She also wondered if the New York state Native programs could be included in the funding for training. She expressed appreciation for making trauma-based treatment a Branch priority.

Ms. Harris responded that to the best of her knowledge, there are no training grants available specifically for schools in CSAT, but that CSAP may have these. The DFO said she would connect Dr. Jircitano to Robert Vincent in CSAP. Ms. Harris added that school districts are eligible for the new PYO treatment program grants and that all youth programs in CSAT emphasize integrating trauma-informed practices into substance use treatment, prevention, and recovery services.

Topic: Health Systems Branch, DSI

Navind D. Oodit, PharmD, MHA, RPh., Branch Chief, gave an overview of the Health Systems Branch, which has two teams—the HIV team and the Medication-Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA) team. The HIV team takes a syndemic approach to healthcare delivery based on the populations served. Strategic priorities include low-barrier SUD treatment, mental health care, viral and hepatitis testing and treatment, HIV prevention, including condom use, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) distribution, and harm reduction services. Other Branch priorities include hepatitis C elimination, including testing and avenues to treatment; continued focus on Mpox vaccination; and harm reduction services.

Dr. Oodit highlighted Branch accomplishments, including initiating three new funding streams. This consists of the MHAF fund, which is among the first of its kind to focus on the unsheltered population. Three recipients applied and were awarded a total of \$2 million for up to 3 years. In the coming year, the MAI HIV anticipates up to 44 awards (including up to five for tribes/tribal organizations); the MAT-PDOA expects up to 24 awards (including up to 13 for tribes/tribal organizations).

Future activities and plans include expanding the MHAF pilot programs to more than three grant recipients and collaborating with prevention colleagues on the MAI grants. Dr. Oodit concluded the presentation by informing the council that in a meeting of the Presidential Advisory Council on HIV and AIDS (PACHA), there was a discussion of an HIV outbreak in Appalachia triggered by injection drug use. Such events illustrate the need to return the information shared at this NAC meeting to the grantees to serve them better.

Council Discussion/Questions

Dr. Fitzgerald commented that she encounters many individuals living with HIV who have fallen out of care and have untreated or undertreated SUD. She thanked SAMHSA for the work they are performing to address this. She asked if the information presented could be shared with individuals living with HIV who have not used substances through a needle. She wondered if other council members had information to share about HIV prevention and access to medications, particularly for the uninsured. She also asked if any Council member could address the burden on healthcare professionals to implement prescribing of HIV preventative medications and treatment within community settings since that is where patients are coming for addiction treatment. Can these services be integrated to reduce workforce burden?

Dr. Oodit stressed the value of the HIV team's syndemic approach because it acknowledges that a combination of factors is related to the increase in HIV and substance use. Regarding information dissemination, the team works closely with the federal departments, the White House, and social media to disseminate information on resources.

Dr. Olsen commented that in terms of integration, the hepatitis C elimination and ending the HIV epidemic are two national strategies the Federal Government has undertaken in which SAMHSA has a part. She echoed Dr. Fitzgerald's point that the strategic priority of integrating behavioral health and primary care should consider the added burden that would be placed on the healthcare workforce.

Topic: Quality Improvement and Workforce Development Branch, DSI

Kim Thierry English, M.ED, CAC, MAC, Branch Chief, presented information on the Quality Improvement and Workforce Development Branch within DSI, which has seven initiatives. Most of the programs are recovery-centric, diverse, and focus on equity. The Recovery Community Support Program (RCSP), Building Communities of Recovery Program, and the Treatment Workforce Support Initiative are included. They are training participants to obtain

viable employment with livable wages. Also, they have two programs designed specifically to develop racial/ethnic minorities in the behavioral health and substance use fields, namely the Center for Excellence and the Minority Fellowship Program (MFP). Notable achievements of the Branch include launching seven NOFOs in FY23, celebrating the 50th anniversary of the HBCUs in the MFP Program, completing the preliminary Congressional report as required by the SUPPORT Act, and the involvement of a subject-matter expert with extensive background in homeless populations who sits on their internal and external working groups.

Future activities and plans include strengthening partnerships and collaborations with the Department of Labor for their Treatment and Recovery Workforce Support grant and the ONDCP for a Recovery-Ready Workforce Summit. They plan to enhance grantee learning opportunities through in-person site visits and to continue promoting SAMHSA's evidence-based recovery practices. They firmly address the social determinants of health that promote economic stability, such as education and healthcare quality. They will coordinate their recovery-friendly workforce initiative while ensuring their efforts are equitable, inclusive, and diverse.

Council Discussion/Questions

Dr. Jircitano inquired if the social determinants of health grants include youth who are asylum seekers and entering the country without resources or family support.

Ms. English responded that the grants have no criteria to exclude any asylum-seeking individuals from accessing their services.

SAMHSA Leadership Discussion with CSAT Council Members

Dr. Olsen introduced Dr. Miriam Delphin-Rittmon, Assistant Secretary for Mental Health and Substance Use, emphasizing her exceptional dedication as a champion, advocate, and role model for advancing mental health and substance use initiatives. Her unwavering commitment has brought about positive changes in individuals and communities across the nation. Dr. Delphin-Rittmon wholeheartedly embodies SAMHSA's mission to pave the way for a healthier future for all. At Dr. Olsen's request, each NAC member introduced themselves to the presenter.

Dr. Delphin-Rittmon warmly welcomed the council members present in person and those joining virtually. She expressed her gratitude for the chance to resume the previous quarterly Council meeting discussion.

She informed the Council that SAMHSA just celebrated its first anniversary of the 988-call center, which has a strong infrastructure and capacity. A total of 5 million calls, texts, and chats were received. This lets us know that people are struggling but are reaching out and consider 988 as a viable resource. The data show that chat and text are the preferred modes of contact for young people. Average call and wait times in states across the country were reduced from about 2 minutes and 39 seconds down to 41 seconds, allowing 988 to connect more quickly with individuals who need help and support. At the anniversary celebration in New York City, SAMHSA launched the Spanish text and chat for 988, which contributes to the agency's goal of getting the word out about the availability of the 988 resources to the states and territories. This

is happening through media coverage and the 988-call center team. She encouraged Council members to explore the many digital shareables and resource toolkits on the website and share, post, and/or print them. She acknowledges that it will take a village to get the word out. As such, they plan to connect with cities and communities in various ways to inform them about 988. For example, in September, SAMHSA will launch a deaf and hard-of-hearing video chat function in response to learning that this population is underserved and under-resourced. Events are also planned for September, Suicide Prevention Month and Recovery Month.

In July, SAMHSA had a well-attended Summit on the White House Initiative on Asian American, Native Hawaiian, and Pacific Islander Mental Health. The Summit had four sessions: addressing Asian American and racial violence; integrated care; 988 and CCBHCs; and language access. Key emerging themes included continuing efforts to raise awareness about services and support, developing strategies to improve access, the important role of partnerships to increase awareness and access, and equity. Follow-up meetings are occurring to flesh out ideas raised in the Summit around those themes. She shared that four workgroups were established to develop an Asian American/Pacific Islander policy agenda.

Dr. Delphin-Rittmon addressed questions raised by council members at the last quarterly meeting about the 42 CFR Part 2, for which SAMHSA received about 200 comments. Part 2 imposes different rules related to SUD-related treatment records and HIPAA treatment records. Congress required SAMHSA to develop and disseminate rulemaking to align HIPAA and Part 2 better. Ultimately, that is what the rule does. There were many changes, and new content areas were added (e.g., permitted use and disclosure of Part 2 records with an individual's consent; permitted redisclosure of Part 2 records in any matter permitted by the HIPAA rule).

Dr. Delphin-Rittmon asked Dr. Olsen if she had any information about the potential timeline for completion of the 42 CFR Part 2. She responded that SAMHSA has been working with the Office of Civil Rights (OCR), which is the office where HIPAA sits, but she did not have a timeline.

Dr. Delphin-Rittmon then focused the discussion on Part 8, for which SAMHSA received about 400 public comments in response to the Notice of Proposed Rulemaking issued in December 2022. The comments can be grouped into three categories: terminology addressing stigma, treatment changes, and accreditation. The goal of Part 8 is to establish a framework for permanently incorporating the flexibilities that were in place due to the COVID-19 pandemic and advancing access to service through telehealth and integration of care. Examples include initiating methadone using audiovisual technology and medical reviews by practitioners external to the OTPs. Other Part 8 matters include reducing stigmatizing language and addressing the range of possible services for mobile medication units. She remarked that much creativity is evident in how communities nationwide use mobile units to help individuals with SUD.

Dr. Delphin-Rittmon informed the council that numerous inquiries have been received regarding contingency management. SAMHSA collaborates with partners across HHS to further explore contingency management as an evidence-based practice and identify the most effective approaches. In April, they convened an in-person meeting on this subject where it was

recommended that training and education curricula should encompass topics such as preparedness and foundational groundwork, implementation strategies, and quality assurance.

Council Discussion/Questions

Dr. Delphin-Rittmon invited council members for an open discussion on any significant aspects of their day-to-day work that they believe SAMHSA should consider regarding substance use or treatment.

Dr. Geminn stated that he and others on the state level are looking forward to the final publication of the Part 8 rules and anticipate that the blanket waiver will not be eliminated. Dr. Delphin-Rittmon responded that the objective is to expedite the release of the final rules, and they are committed to integrating learnings that proved impactful during the Pandemic.

Dr. Petit commented that the Federal Government and the states have been pushing CCBHCs. He asked if pushing for the Prospective Payment System (PPS) model of financial reimbursement versus a grant was possible. He elaborated that 10 or 13 states participated in a demonstration project using the PPS model and that SAMHSA grants are less flexible, especially with respect to wraparound services.

Dr. Delphin-Rittmon stated that they have observed various CCBHC models and diverse responses from state systems. Another model involves CCBHCs funded by the states, which may not necessarily be integrated into the state Medicaid Plan but are funded directly through grant dollars. Congress has also heavily invested in another model, the CCBHC-Expansion, which introduces a prospective payment system through Medicaid.

Dr. Tanner-Smith asked to hear more about plans around contingency management. What are the next steps? She works primarily with schools and youth-serving community organizations and finds one of the biggest barriers to implementation and sustainability is getting the funding to implement contingency management approaches.

Dr. Delphin-Rittmon stated that they are closely examining the data and evidence related to contingency management and working to put things through appropriate clearances and other processes.

Dr. Fitzgerald expressed her gratitude to SAMHSA for funding the consultation service that she started. She relayed stories of how the service enables critical work on the ground to treat patients of all ages, which is essential and could not occur without these funds.

Dr. Delphin-Rittmon acknowledged the value of being in the position to have an initial consultation followed by triage work to meet the challenges of getting individuals the appropriate support they need. SAMHSA is looking to incorporate language into the NOFOs that address co-occurring conditions and to create more entryways and opportunities to get individuals with co-occurring challenges into care.

Dr. Peoples offered observations from her work in the District of Columbia with individuals under supervision through the court system who have co-occurring substance use and wide-ranging mental health disorders. They perform comprehensive assessments and refer to community-based programs for substance use services, but those services have really dried up in the last several years. Another problem is that the District of Columbia has no group homes or other appropriate housing to place individuals reentering the community. There is one provider for short-term residential treatment and one for outpatient treatment. She asked if SAMHSA is working to help programs in the community.

Dr. Delphin-Rittmon responded that their grants aim to have multiple entryways and options for individuals to connect and get supported through care. The diversion programs seek to help people connect to services and support so they will not experience unnecessary justice involvement. CCBHCs are geared towards helping to provide a range of wraparound services, including substance use, mental health, case management, and housing support. Prevention and early intervention programs such as Project AWARE are other resources. SAMHSA is trying to look at the full portfolio of programs across its centers and offices to identify the gaps and determine how to intervene. The National Survey on Drug Use and Health (NSDUH) data is being examined to understand better some of the patterns, trends, and drivers.

Dr. Olsen added that housing for reentry and individuals with substance use and mental health challenges is becoming more of an issue and might be on the agenda for discussion at the next NAC meeting. She also noted that the CSAT grant programs have provisions for allowable activities for recovery housing.

TOPIC: Harm Reduction

Christine Rodriguez, MPH, Senior Program Manager, Harm Reduction, AIDS United

Ms. Rodriguez presented SAMHSA's Harm Reduction Framework (HRF)—which is in the draft stage and working its way to be finalized—covering its definition, six pillars, 12 principles, and six core practice areas.

“SAMHSA defines harm reduction as a practical and transformative approach that incorporates community-driven public health strategies—including prevention, risk reduction, and health promotion. Its intent is to empower people who use drugs (PWUD) and their families to live healthy, self-directed, and purpose-filled lives. Harm reduction centers the living and lived experiences of PWUD, especially those in underserved communities, in these strategies and the practices that flow from them. SAMHSA conceptualizes harm reduction as a set of practices, a type of organization, and an approach.”

She stated that it is important for individuals who use drugs to seek leadership and define their priorities proactively. She also explained that harm reduction can be embraced as a guiding philosophy and applied consistently.

Ms. Rodriguez outlined the six pillars of the HRF as follows:

- They are guided by people who use drugs and have lived experience.

- They embrace people's inherent values and treat them with respect, dignity, and positive regard.
- They commit to deep community engagement and community building.
- They promote equity, rights, and reparative social justice.
- They offer the lowest barrier access and non-coercive support.
- They focus on any positive change as defined by the person.

The pillars are the essential building blocks that form the foundation of harm reduction and contribute to its success. Harm reduction initiatives, programs, or services should include these elements. The pillars are supported and reinforced by 12 core principles that guide the work. As with the pillars, all principles (e.g., prioritize listening, respect authority, practice acceptance and hospitality, and provide safety, to name a few) are vital. Programs that do not incorporate all 12 principles risk violating the spirit of harm reduction.

Ms. Rodriguez highlighted the six core practice areas of the HRF, which are safer practices, safer settings, safer access to healthcare, safer transitions to care, sustainable workforce and field, and sustainable infrastructure. While not an exhaustive list, these are effective methods for harm reduction that reflect community understanding, experience, strengths, and needs. She noted the significance of respecting the wisdom and expertise of individuals, emphasizing that harm reduction frequently fosters innovation from drug users that can complement established scientific strategies. It is also crucial to consider the intersectionality of identities, including race, class, and sexual orientation.

Council Discussion/Questions

Dr. Jircitano asked how the HRF squares with the philosophy of Alcoholics Anonymous to avoid exposure to people, places, and things that induce individuals to begin using again. What happens when we test and find an individual is not using their maintenance drug as opposed to their street drug?

Ms. Rodriguez addressed the first question by suggesting that in the context of harm reduction, if Alcoholics Anonymous (AA) is effective for an individual and supports them, they should continue with it. However, if AA is not proving beneficial, they should explore its appreciated aspects and see if they can still be applied. Within the HRF, there is ample room to incorporate various modalities. In response to the second question, she noted that when an individual receives an appropriate medication dose from a licensed physician, it can offer stability and potentially serve as a pathway toward cessation.

Dr. Olsen commented that there is much evidence that medications—buprenorphine, buprenorphine/naloxone (Suboxone™), or methadone—can reduce mortality and save lives. Also, there is much misinformation about what addiction is, what substance use disorders are, and what opioid use disorders are. The DSM-5 notes the distinctions.

Dr. Geminn stated that we should not assume that people do not have a stigma towards medications, even if they are in the recovery space.

Dr. Peoples commented that individuals referred to their program typically want to avoid coming to the program. Law enforcement supports abstinence. How does the HRF work with law enforcement agencies in terms of abstinence?

Ms. Rodriguez said that law enforcement has a completely different charge, mission, and history and acknowledged that is complex and challenging.

Dr. Olsen stated that the trauma-informed piece is incredibly important from CSAT's perspective. CSAT can recognize the trauma incarceration and engagement with law enforcement can have on individuals, and help people through grants, policies, programs, and technical assistance to stay out of the criminal justice system.

Dr. Jircitano asked if there is a biopsychological basis to examine the origin of an individual's trauma.

Dr. Peoples stated that in therapy, we talk about the changes in the brain due to trauma, which can include historical or generational trauma.

Dr. Hyde stated that SAMHSA asked for commentary on the HRF when it was released a few weeks ago, and she provided comments. We must focus on language to help reduce stigma, misinformation, and miscommunication. She asked who thought that labeling was appropriate and if there has been a discussion on how individuals want to be identified (e.g., as a person who uses drugs or engages in harm reduction). She is working with law enforcement in Kentucky and noted there needs to be more discussion about the intersection of harm reduction and law enforcement.

Ms. Rodriguez responded that language and identity are areas that harm reduction has grappled with for a while without much consensus. Even the term harm reduction can be highly stigmatized. Regarding identity, it is best to ask the individual how to refer to them directly. We do not identify individuals who use alcohol the same way as those who use drugs.

Dr. Stoller stated he does not disagree with any of the values outlined in the HRF, but he does not approach treatment as having to be "directed" by the patient at all times - that is not what is meant by patient-centeredness. The problem is that decisions made during active addiction often serve the addiction and are a product of the very disorder the patient has come to have treated. There are things providers can do, when they are trained in the treatment of behavioral health problems, that help patient engagement be driven forward, and discourages destructive behavior. Good treatment offers benefits to patients that drives engagement and overcomes the drive to use drugs and alcohol.

Ms. Rodriguez commented that motivational interviewing is a great tool that laypeople can easily use.

Dr. Fitzgerald stated it would be helpful if grant funds could be used to bill or invoice items such as low-barrier housing, food, or transportation. She commented that harm reduction is for everyone except those subject to nonconsensual drug testing such as mothers and their infants at delivery.

Dr. Geminn pointed out that there is a role for people like him who do not have lived experience or identify as a drug user or minority but offer support and compassion.

TOPIC: Stigma and Discrimination in Substance Use Disorders

Twyla Adams, MHS, Public Health Advisor, presented statistics and other information in areas of importance to the SUD field, which encompassed drug overdose deaths; SUD treatment needs; SUD stigma, discrimination, disparities, and inequities in racial/ethnic and underserved communities; and SAMHSA and CSAT activities to address treatment barriers such as stigma and discrimination to increase access to SUD treatment.

SAMHSA and CSAT are addressing the unprecedented loss of life in the U.S. from fentanyl-driven overdoses and, increasingly, stimulants exacerbated by the isolation, stress, and anxiety associated with the COVID-19 pandemic. Stigma and discrimination keep many people from engaging in treatment, partly from a lack of understanding that SUDs are chronic, treatable medical conditions.

Ms. Adams shared that stigma, negative attitudes, and stereotypes against people with SUDs can create barriers to treatment, especially in racial/ethnic underserved communities. They face barriers such as lack of insurance, transportation, accessibility, language translation, and childcare. There are cultural barriers and beliefs, such as a mistrust of methadone and needle and syringe exchange programs in some black communities and the negative stigma associated with methadone treatment compared to buprenorphine. The Centers for Disease Control and Prevention (CDC) reported that from 2019 to 2020, drug overdose deaths increased by 44 percent among non-Hispanic blacks and 39 percent among non-Hispanic American Indian and Alaska Native persons. Most of these individuals had no evidence of SUD treatment before their deaths. In addition, overdose deaths among black males 65 and older were nearly seven times that of their non-Hispanic male counterparts. Disparities in overdose deaths, particularly among black persons, were larger in counties with greater income inequality. Opioid overdose rates in 2020 were higher in areas with more opioid treatment availability compared with areas with lower opioid treatment availability, particularly among black and, American Indian and Alaska Native persons.

Ms. Adams continued by sharing the following statistics and details about racial/ethnic inequities in SUD treatment and mental illness:

- The 2020 data from SAMHSA's NSDUH show that over half of black adults aged 18 or older with mental illness did not receive treatment within the past year.

- Far fewer black adults sought help for SUD or co-occurring SUD and any mental illness. Over 90 percent did not receive treatment, highlighting barriers to treatment, including stigmatization of SUD.
- Black persons who access substance use treatment have significantly lower rates of outpatient substance use treatment completion than white patients. Those who complete it have significantly longer lengths of stay.
- Over half of Hispanic adults aged 18 or older with any mental illness and Hispanic youths aged 12 to 17 with a major depressive episode did not receive treatment within the past year. Far fewer adults sought help for SUD. Over 90 percent do not receive treatment, highlighting barriers to care, including stigmatization of SUD.
- Notably, similar data from the 2020 NSDUH was not available for American Indian and Alaska Native persons due to low precision. This speaks to limitations in national datasets and the need to include racial and ethnic underserved communities in designing and participating in research and evaluation processes.
- Combined data from 2004 to 2015 from the National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey demonstrated that black patients had significantly lower odds of receiving buprenorphine prescriptions even after controlling for payment method, sex, and age.
- Kilaru conducted a 2020 cohort study on insured people who suffered nonfatal overdoses and were treated at an emergency room. Black patients were found to be half as likely to obtain treatment following nonfatal overdose compared with non-Hispanic white patients, even when privately insured.
- The 2020 NSDUH data report that only 1.1 percent of people with SUD in the general population seek treatment. This is magnified in black and Latino communities, where there is significant historical mistrust of the healthcare, social service, and justice systems.

Ms. Adams shared information on racial/ethnic inequities in SUD and mental illness as it relates to the criminal justice system and incarceration:

- Black men fear that seeking treatment will result in severe sentencing and incarceration, which reflects the disproportionate impact of drug laws and harsh policies of the past. Stricter drug policies for the possession or sale of heroin in New York, known as the Rockefeller laws, were implemented in 1973.
- The Anti-Drug Abuse Act of 1986, enforced across the country, resulted in mandatory and severe sentencing for low-level, nonviolent drug offenses, particularly related to cocaine, for a disproportionately high number of people of color compared to white Americans.

- These severe penalties have had lasting impacts on the current criminal justice system, where black Americans represent a substantial percentage of drug offenders in federal prison despite white Americans representing most illicit drug users in the United States.

Ms. Adams presented information on what SAMHSA and CSAT are doing to address these issues:

- SAMHSA's five priority areas are: Enhancing access to suicide prevention and crisis care; promoting resilience and emotional health for children, youth, and families; integrating behavioral and physical healthcare; strengthening the behavioral health workforce; and preventing overdose. The agency's four critical cross-cutting principles are equity, trauma-informed approaches, recovery, and commitment to data and evidence.
- CSAT's priorities and principles reflect those of SAMHSA. The CSAT priority areas include equity assessments, incorporation of harm reduction and recovery-oriented care, contingency management implementation, hepatitis C elimination, intersection with alcohol interventions, MOUD expansion as a tool and a connector, and methadone modernization.
- Of CSAT's priorities, there is a significant focus on expanding MOUDs due to their many benefits. Research spanning over two decades has shown that increasing access to methadone and buprenorphine saves lives and reduces healthcare costs in conjunction with other comprehensive treatment strategies.
- Mortality studies have shown the positive impact of expanding treatment with medications for opioid use disorder, resulting in a 37 to 80 percent reduction in overdose mortality. A study of Medicaid beneficiaries with opioid use disorder found that substance use treatment incorporating medications is associated with reduced inpatient hospital admissions and outpatient emergency department visits.
- By promoting the expansion of methadone and buprenorphine treatment, we can address some treatment barriers that racial/ethnic underserved communities face, increase access and improve outcomes for individuals with opioid use disorders, and help save lives.

Ms. Adams concluded her presentation by acknowledging that much more work remains for SAMHSA and CSAT in addressing treatment barriers such as stigma and discrimination to increase access to SUD treatment for racial/ethnic underserved communities. She highlighted selected information from the literature related to research, evaluation, policy, and practice that are consistent with SAMHSA's strategies and others that could be adopted:

- The literature on nonmedical prescription opioid use has relied largely on national datasets and focused on examining racial differences. Thus, in-depth results on subgroups are limited, and conclusions may lack relevance or context for racial/ethnic communities.

- Research study participants may not recognize the pharmaceutical names for opioids or other prescription drugs. This can impact culturally relevant messaging if targeted populations do not understand the language used.
- Research is needed that targets explicitly racial/ethnic underserved communities with histories of cocaine and heroin use in the wake of increased overdose deaths associated with fentanyl. The use of rapid fentanyl test strips has proven to be a promising harm reduction approach to overdose prevention.
- Given the risk of overdose among older black persons and those newly reentering the community from prison or jail with prior histories of cocaine and heroin use, targeting these vulnerable populations for clinical research with fentanyl test strips could substantially impact overdose prevention.
- It is important to increase access to Naloxone in racial and ethnic underserved communities. Black, Hispanic, and Latino communities are more likely to be criminalized for drug use and, therefore, may be less likely to approach law enforcement officers or first responders to request Naloxone.
- Increasing the availability of Naloxone through distribution when a person is released from jail or prison, coupled with targeting underserved communities for Naloxone education, could also reduce increasing overdose death rates among these groups.

Additional policy and practice considerations include offering culturally appropriate practices and treating people from various settings, including those within the community, creating culturally tailored campaigns to raise awareness and reduce stigma, building structural support to reduce treatment barriers, and offering telehealth services.

Council Discussion/Questions

Dr. Stoller commended Ms. Adams for delivering an excellent presentation and conveying meaningful action points for SAMHSA and CSAT. He concurred that offering telehealth services is valuable for bolstering SUD and mental health treatment options and addressing inequities. He added that the digital divide needs to be addressed, contributing to inequities in treatment in racial/ethnic underserved populations because many people do not have the proper technological devices or do not know how to use them.

Dr. Peoples commented that her program offers telehealth services as part of outpatient treatment, engages people, and increases access. Given the level of mistrust, she asked what efforts SAMHSA is considering to expand its outreach to underserved populations for participation in research studies.

Ms. Adams replied that they are partnering with the NIH, particularly NIDA, in this area, and a HEALing Communities Study is underway. Dr. Olsen further explained that it is a large, four-state, randomized trial implementation science study examining different treatment interventions, approaches, and equity issues. The participating states are Kentucky, New York, Ohio, and Massachusetts. The study also contains a community coalition component and a communication

campaign. Data collection will be completed in December, and several publications have already been released, with many more to come. SAMHSA does not directly fund research but partners with other agencies. She agreed that engaging racial/ethnic underserved people in research or services is challenging due to historical mistrust of the healthcare and law enforcement systems. She acknowledged that there is still much work to be done by all.

Ms. Hyde shared her familiarity with the HEALing Communities Study, given her location in Kentucky, including its successes and challenges. She noted that many parents of young children in the state have died because of overdose and would like to know if this is happening nationwide. Additionally, she called attention to the latest report from the ODCP in Kentucky, which showed a decrease in overdose deaths in the state over the last year. However, overdose deaths of members from the black, indigenous, and people of color (BIPOC) communities have increased, although this data has not necessarily been discussed.

Dr. Jircitano emphasized the need for increased research in underserved and geographically isolated communities, such as Native American and black communities, which embody significant mistrust. She explained that Native Americans have historical memories of fur traders providing them with alcohol in the 1600s to secure more furs for shipment to Europe. This practice became a means of leverage, perpetuating indebtedness within their communities through written offers. Alcohol became a preferred commodity for traders to acquire Native American land.

She advised that to increase research in racial/ethnic underserved communities, it is essential to identify sources of support and funding for doctoral programs to attract and cultivate a larger pool of minority scientists in the fields of alcohol and substance use, as well as public health. She commented that the recent Supreme Court decision that universities cannot use race as a criterion for admission will hamper research and policy development because Native Americans will not trust university researchers from their own culture.

Dr. Olsen thanked Dr. Jircitano for her remarks and noted the importance of the minority workforce development piece. She invited Ms. English and Ms. Adams to respond. Ms. English stated that SAMHSA has the MFP and HBCU Programs, both on the undergraduate and graduate levels, to increase the number of minorities in SUD and behavioral health careers. The MFP just celebrated its 50th anniversary, and the HBCU Program has existed for quite some time. She reiterated that the Assistant Secretary is an alumna of the MFP. SAMHSA also has an internship program for minority students.

Dr. Olsen stated that this topic may become an agenda item for the next CSAT NAC meeting to dive deeper into the MFP and HBCU Center of Excellence. She mentioned that CSAT has been in discussions with CMHS and CSAP on strategies to increase the number of minority students and researchers in the workforce pipeline with substance use and behavioral health careers. She expressed the desire to support even younger generations of individuals of color to become interested in behavioral health careers and assist them with higher education in this field.

Ms. Adams added that CSAT has 13 Addiction Technology Transfer Centers (ATTCs), and nearly all have leadership development academies that reach out to students in undergraduate and

graduate schools to cultivate leadership skills they can use to help transform systems. For example, the National Hispanic and Latino ATTC has a phenomenal leadership academy and will soon graduate their fourth cohort of leaders. There is also the National American Indian and Alaska Native ATTC, which has a leadership academy.

Dr. Petit asked how we can sensitize people to understand the complexities around SUD and mental health. Why are these topics, or resources like Mental Health First Aid, not included within high school curricula? Even healthcare professionals need more training on medications for addiction treatment. In addition, he echoed remarks made by other council members that America's healthcare system is incredibly inequitable, with many social determinants of health that must be addressed.

Dr. Olsen noted the importance of comments by Dr. Petit and other council members and said they try to weave these issues into all the NOFOs and grant programs to help ensure that grantees have the necessary resources.

Dr. Juliana remarked that the ONDCP issued the National Drug Control Strategy. One included strategy is to infuse SUD education into graduate-level programs for all healthcare professions. Also, there was an interagency committee on professional education in opioid use and intervention that Dr. Olsen and Dr. Marta Sokolowski from the Food and Drug Administration (FDA) co-chaired. When the MATE Act was implemented, SAMHSA, with input from federal partners, professional associations, and external experts developed a document on recommended curricular elements for SUD training. This can be found on the SAMHSA website. . The ONDCP also recently held a meeting with the lead accrediting bodies for healthcare education, which generated three ongoing groups: one to identify and track people with SUD throughout healthcare, one to develop a curriculum, and one to track workforce development.

Dr. Olsen added that the curricular elements for SUD training included stigma, trauma, and equity as key topics to raise awareness and promote action.

Dr. Stoller suggested that a regional approach to implementation may be helpful. He is part of a learning collaborative that meets quarterly with school leaders from different regions who benefit from sharing information, ideas, and strategies that elevate their training in SUD.

Dr. Julianna concurred that a regional implementation model is beneficial and is being used through the ATTCs, which are nearly all University-based. She added that the Council on Social Work Education, the accrediting body for social work, took the lead five years ago and infused SU education as a standard in their accreditation processes. They are part of the Prac-Ed funding and receive about \$500,000 annually to post curriculum and teaching tools.

Dr. Stoller noted that the learning collaborative he referenced included the National Association of Social Workers (NASW) and the National Association of Social Workers in Education (NASWE).

Dr. Jircitano said we should fund school programs that include informed trauma care. In Tuscarora, the local district superintendent has trained all teachers in trauma and trauma-informed childcare theories. A grant did not fund this work.

Dr. Olsen brought the discussion to a close by emphasizing that education in SUD and mental health is essential for healthcare professionals and the public. This education can play a crucial role in dispelling myths, addressing misinformation, and increasing understanding. As Dr. Geminn pointed out earlier, there is a growing awareness of the importance of discussing adverse childhood experiences and positive ones that can promote resilience. Research in this area is likely limited and should be considered a potential agenda topic for future Council meetings.

Public Comment

The DFO stated that no written submissions for public comment have been received. She asked if any members of the public would like to address the council and provided instructions for doing so. There were no comments from the public.

RECAP: Putting it all Together

Dr. Olsen thanked the council members for their participation and reminded them of the Joint NAC meeting taking place the following day. She stated she would prepare a brief write-up of key points discussed at today's CSAT NAC meeting for a report-out tomorrow and invited anyone who desired to contribute to the report-out to do so. The points to be mentioned in the write-up include discussions on data collection that is useful to practitioners and organizations; harm reduction and its intersections with criminal justice, treatment, and different communities; stigma, discrimination, and the disproportionate impact of overdose on black and brown communities; workforce opportunities; the push for broader education on SUD; and infusing social determinants of health into grant programs to improve access to medications and services and enhance quality of life.

Adjourn Open Meeting

The DFO requested a motion to adjourn the meeting. Dr. Petit moved to adjourn, and Dr. Stoller seconded the motion. All members voted in favor. The meeting was adjourned at 4:01 p.m.